Strategy Research Project

ASSISTING HOST NATIONS IN DEVELOPING HEALTH SYSTEMS

BY

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ASSISTING HOST NATIONS IN DEVELOPING HEALTH SYSTEMS

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ABSTRACT

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Historically, the Department of Defense (DOD) provides medical assistance to other nations as part of stability and reconstruction operations in response to natural disasters. Medical civic action programs (MEDCAPs) and medical readiness education and training exercises (MEDRETEs), are also part of geographic combatant commander's theater engagement strategies. While noble and providing immediate and short-term relief, the development of comprehensive health support systems of these nations is still lagging. The US Agency for International Development (USAID) is the lead agency for strengthening the health systems of developing countries, but its resources are limited, and rarely engage in countries undergoing internal conflict. The United States has an opportunity to redefine the DOD's role in providing medical support to foreign or fragile nations. Through better partnerships with non-governmental organizations and international organizations, the US military can assist fragile nations in developing their own sustainable health care system.

ASSISTING HOST NATIONS IN DEVELOPING HEALTH CARE SYSTEMS

> We must recognize that the Department of Defense contribution to interagency operations is often more that of enabler (versus decisive force, a function we are institutionally more comfortable with.)
>
> —General George A. Joulwan, USA
> Commander, US European Command
> 21 October 1993 – 10 July 1997

The United States (US) has a long history of providing health support to foreign nations, and it does so in various forms. The Department of Defense (DOD) conducts medical civic action programs (MEDCAPs), and medical readiness, education, and training exercises (MEDRETEs) as part of geographic combatant commander's security cooperation plan with foreign nations. As seen in the responses to the natural disasters such as the tsunami that struck Indonesia in December 2004 or the ongoing Haiti relief Joint task force operations in the response to the 12 January 2010 earthquake, the DOD is the best equipped US government organization that can alert, mobilize and deploy the required personnel, equipment, and capability to provide immediate health service support operations to the affected populations. Following combat operations, medical objectives during stability, security, transition, and reconstruction operations include the restoration of public health, and essential medical care with the desired military end state.[1]

While noble in their intent, "the vast majority of these military medical humanitarian assistance projects involve providing direct patient care services, often for very short periods of time, leaving the problems in medical and public health infrastructure unresolved and unfortunately often unaddressed."[2] Poor or devastated countries with minimal health infrastructure cannot provide the same quality of care

offered by US personnel once they depart.[3] However, currently it is not the DOD's mission to lead the construction or reconstruction efforts of these nations in crisis.

The US Department of State's (DOS) Office of the Coordinator for Reconstruction and Stabilization (S/CRS) has as its core mission to "lead, coordinate, and institutionalize US Government civilian capacity to prevent or prepare for post-conflict situations and to help stabilize and reconstruct societies in transition from conflict or civil strife so they can reach a sustainable path toward peace, democracy, and a market economy."[4] The DOS is under-resourced both in manpower and budget to accomplish this mission effectively. In the President's 2010 Budget, the funding for the S/CRS "requests $323.3 million for the Civilian Stabilization Initiative (CSI) to build our nation's civilian capacity for reconstruction and stabilization efforts"[5], while the same budget requests for the Defense Health Program (DHP) "includes a total of $47 billion in health care costs."[6], an increase of $1 billion from the fiscal year 2009 DHP budget.[7]

Additionally, private volunteer organizations (PVOs), international organizations (IOs), and non-governmental organizations (NGOs) are usually present providing care and services to these disadvantaged populations. Although the Department of State (DOS) is the lead for coordinating health care assistance to foreign nations, the DOD has a more robust inventory of assets and military and civilian expertise to better assist nations, in conjunction with the US Agency for International Development (USAID) to build self-sustaining health care systems. By better partnering with the DOS/USAID, civilian humanitarian organizations, and the host nation government, US military medical personnel can better assist and lead the development and reconstruction of long-term, self-sustaining health care delivery systems in post-conflict nations.

Historical Examples of Health System Reconstruction

US military medical personnel are knowledgeable and experienced in all facets of health care, from acute treatment and evacuation of ill and injured from the battlefield to definitive care and rehabilitation in tertiary care medical centers in the continental United States. They are also experts in health care administration; the Military Health System (MHS) is the one of the largest health care systems in the world. Composed of 59 hospitals and 364 health clinics throughout the word, it is a global medical network, within the US Department of Defense, that provides high quality health care worldwide to beneficiary population of 9.6 million service members, veterans, and family members.[8] In order to be more effective trainers and mentors to foreign medical professionals in establishing or improving their own health care systems, DOD medical personnel need also to be familiar with the lessons learned from our own past experiences in building health care systems and learn about and develop a better understanding of how other nations practice medicine. We need to provide foreign nations assistance on how to best administer their medicine to their people, not simply establish a carbon-copy of the US health system on a non-US society.

RAND examined historical cases from post-World War II Japan, the conflict in Kosovo at the turn of this century, and Operations ENDURING FREEDOM and IRAQI FREEDOM currently ongoing in Afghanistan and Iraq respectively on the post-conflict reconstruction of the respective nations' health care systems. Japan's successful reconstruction of its health care system was accomplished by system-wide reforms in disease prevention, reorganization of their hospital system, and reforms in medical education. This success was in part due to the ability of US military medical personnel operating in a secure and safe environment.[9] Also, there was no armed insurgency

targeting the civilian population like that seen in the stability and reconstruction phases of Operation IRAQI FREEDOM. Not a single member of the occupying forces was killed by Japanese citizens nor were the Japanese victims of American attacks.[10] Issues of security were quickly turned over to Japanese police, allowing the occupation authorities to concentrate on political and social reform, economic restructuring, reconstruction, and development.[11] The physician in charge of overseeing the rebuilding of Japan's health care system, COL (Dr.) Crawford F. Sams, argued that reconstructing the Japanese health system "did more than perhaps any other single action to prove that the United States was committed to building a vibrant, functioning democracy out of a former enemy state."[12]

Kosovo is an example of mixed success. Following the 1999 conflict in Kosovo, United Nations (UN) Security Council Resolution 1244 created the UN Administrative Mission in Kosovo (UNMIK), under which fell the Department of Health.[13] The Department of Health chose to both reform the health system that existed prior to the conflict while it simultaneously undertook a major reconstruction effort.[14] The previously existing health care system, during the socialist days when Kosovo was part of Yugoslavia, was expansive, centralized, treatment-, hospital-, and doctor-oriented.[15] There was a network of one university hospital, five district hospitals, thirty municipal health clinics providing secondary care services, and multiple smaller clinics providing primary health care (PHC), which was very inefficient.[16]

The Ministry of Health (MOH) implemented several changes to evolve from a hospital-based system to a PHC, patient-centered system. It decentralized day-to-day management of clinics and health facilities to the district and local levels, and promoted

the family medicine model which serves as the gatekeeper for referral to secondary and tertiary care.[17] The Kosovo MOH opened 24-hour family health clinics that provide preventive medical, dental, diagnostic and emergency care. Priority was given to maternal, child, adolescent, and reproductive health.[18] The UNMIK sent medical leaders abroad to train in health care management or, in conjunction with private donors, organized training courses in Kosovo.[19]

The success of these reforms are mixed, due to a combination of the speed and complexity of the required reforms, decrease in post-war donor financial support, and decrease in MOH's budget.[20] Successes include the streamlining of the health care system from the local health clinics to the major university hospital in Pristina, the refurbishing and reequipping of health facilities, and improvement of the clinics and hospitals administration.[21] Improvements are still needed for better procurement systems and financial and human capital management. Doctors are also gravitating towards more lucrative clinical specialties and private practices, decreasing the number of physicians available to see patients in national-sponsored facilities. Finally, some municipal PHC positions are awarded as political favors.[22]

Iraq is another example of a mixed success. Although back on progress now, the reconstruction of the Iraq health care system suffered as a result of the insurgency that occurred during the stability and reconstruction phase of Operation IRAQI FREEDOM. Hospitals were targeted by the insurgents[23], as were physicians and other health care workers.[24] Since most of the doctors training is done in English, many were hired on by the US government to serve as interpreters, taking them away from practicing medicine. By 2008, "at least 600 medical professionals, including 134

doctors have been killed or threatened."[25] The result was a shortage of health care providers as many health care workers fled the country or relocated to safer regions within the country working in less dangerous trades.[26] This was further complicated by slow progress in reliability of water, sanitation, and electricity, and multiple ministers of health that prevented long term coordination of planning and funding.[27] It was not until late 2007 with the decrease in sectarian violence as a result of Multinational Force - Iraq counterinsurgency operations that positive changes to the Iraq health system could begin. This was also coupled with the appointment of Dr. Salih M. Al Hasnawi as the new Iraqi minister of health. Because of the improved safety conditions, Dr. Salih was able to convince health care providers to return to work for the MOH; he improved their salaries and living conditions, and created incentives to take assignments in rural areas. Even with this positive trend, it will still take years to replenish the health care workforce to pre-2003 levels.[28]

Afghanistan is an example of a failed heath system construction. Since the 1950's, Afghanistan has been dependent on external support for its health system.[29] After Operation ENDURING FREEDOM began in October of 2001, the development of the nation's health system was slow to start; it was not until the beginning of the third year of the war that health services were expanded to the rural areas.[30] As of April 2009, few trained doctors and midwives provide obstetric care in rural areas where 75% of the female population lives. [31] Deficiencies in the rebuilding of their health system included inadequate funding and ineffective communication and coordination among the international and non-governmental organizations and with the Afghan government.[32] A US GAO report found that USAID's program in Afghanistan lacked measurable goals

and specific resource levels, did not delineate responsibilities, contained no plans for evaluation of their program, and also cited poor collaboration and information sharing among all participating agencies.[33]

These case studies illustrate several lessons in which the development of health care delivery systems in support of nation building can be improved upon: (1) health care delivery and subsequent improvement in health of a population can help win hearts-and-minds and have an independent effect on nation building efforts, (2) health system development or reconstruction must include effective planning, coordination, and leadership, (3) health reform is linked to other areas such as power, transportation, and governance, (4) health reform must be sustainable with responsibility passed to the host-nation's health care providers and leaders, and (5) security is a requirement for all reconstruction including health care.[34] Unless the other civilian organizations within the US government receive significant increases in funding and personnel, the DOD will remain the largest, best funded, and better organized US organization that can efficiently orchestrate the improvement of health care systems in support of nation building.

Stability Operations are a Core US Military Mission

There are multiple strategic documents that address the importance of DOD support to stability and reconstruction operations. In 2005, the DOD issued a policy that directed military planners to prepare for military support for stability, security, transition, and reconstruction operations with the same level of attention they place on planning for combat operations, and that "DOD medical personnel must be prepared to meet military and civilian health requirements in stability operations."[35] On September 16, 2009, the DOD issued Department of Defense Instruction 3000.05 which reinforced the policy that

stability operations are a core US military mission, stating that the DOD will be prepared to: (1) conduct stability operations activities throughout all phases of conflict and across the range of military operations, including in combat and non-combat environments, (2) support stability operations activities led by other U.S. Government departments or agencies foreign governments and security forces, international governmental organizations, or when otherwise directed, and (3) lead stability operations activities to establish civil security and civil control, restore essential services, repair and protect critical infrastructure, and deliver humanitarian assistance until such time as it is feasible to transition lead responsibility to other U.S. Government agencies, foreign governments and security forces, or international governmental organizations.[36] Additionally, the 2010 Quadrennial Defense Review stated it is in its international interests that the U.S. military provide assistance to nations in need.[37] Ms Ellen Embry, currently performing the duties of Assistant Secretary of Defense for Health Affairs, recently stated that "improving health and health care independence is just as critical to enhancing stability and preventing conflict as our other missions around the globe."[38]

Winning Hearts and Minds

Before 1985, US humanitarian assistance overseas was primarily limited to where the US had committed ground forces.[39] These forces used their medical assets to provide short-term assistance in order to help pacify the local population.[40] The US saw an opportunity to use limited military medical aid to governments friendly to the US, who were engaged in their own low intensity conflicts, as one way to help win the hearts-and-minds of the local population.[41]

Under Title 10 US Code, Section 401, the US military is authorized to engage in peacetime projects with foreign nations. Medical civic action programs (MEDCAPs) and medical readiness, education, and training exercises (MEDRETEs) conducted under this statute are primarily intended as training opportunities for the DOD, while simultaneously providing non-threatening engagement opportunities with foreign nations.[42] This enhances the geographic combatant commander's ability to expand their cooperation with friendly governments whether or not US military personnel were present on the ground.[43]

During international contingency operations, Title 10 US Code, Section 2551, which permits the DOD to use funds for other humanitarian purposes worldwide, allows the US military to provide assistance to civilians.[44] This assistance includes programs that provide medical care, whether by individual encounters whereby patients are examined, diagnosed, and treated by US military personnel or constructions of clinics, hospitals, and public health projects such as building safe sources of drinking water.

Joint Publication 1.02 defines security cooperation activities as "programs and exercises that the US military conducts with other nations to improve mutual understanding and improve interoperability with treaty partners or potential coalition partners."[45] The DOD annually conducts over two hundred such humanitarian assistance projects throughout the world.[46] Humanitarian and civic assistance projects, conducted under the Overseas Humanitarian Disaster and Civic Aid Program, are a cornerstone of geographic combatant commanders' theater security and cooperation programs, with one-third to one-half of these being health related.[47] MEDCAPs and MEDRETEs have advantages and disadvantages to both the foreign populations served

and the US military personnel who participate. These exercises theoretically build indigenous capabilities and cooperative relationships among the partner organizations, promote peace and stability, and facilitate the development of sensitivity to other cultures.[48] MEDCAPs and MEDRETEs provide US health care personnel exposure to multiple acute and chronic third world diseases and medical conditions they would not usually see in the United States. A disadvantage is they are short-term exercises, and the long-term effectiveness of these programs is uncertain. While designed to provide improvements to the community served, some believe that traditional MEDCAP/MEDRETE activities can be counter-productive to the overall goal of creating confidence in the local government, creating false impressions about the host nations' abilities to meet the populations' needs by building expectations which could not be met after US personnel depart."[49]

On the strategic level, the results of these health diplomacy efforts are mixed. USNS hospital ship visits to Central and South America paid dividends in influencing both populations and government leaders to view the US and its military more favorably, while the USNS MERCY's deployment to Indonesia was more problematic.[50] "The standard of care provided by the MERCY's personnel far exceeded what the Indonesian government was able to provide after the MERCY departed, and Indonesia claimed this had undermined its legitimacy and authority."[51] According to an October 2008 report by the Health and Fragile States Network, "there is little direct evidence to suggest that health-sector activities contribute to the long-term security, stability, governance, or legitimacy of fragile states."[52]

Effective Planning, Coordination, and Leadership

US humanitarian assistance activities overseas, in the context of long-term commitments to nation-building civic improvement projects, are the primary responsibility of civilian organizations within the US government, not the DOD.[53] Smith and Llewellyn questioned this construct in 1992. Justifications in expanding the role of the military in humanitarian assistance operations included legitimate moral and humanitarian reasons, excellent publicity, the potential for augmenting a friendly nation's counterinsurgency strategy, and overcoming the perceived shortcomings of civilian agencies executing effective humanitarian assistance programs in regions considered to be strategically important.[54]

The DOD's role in health capacity building in current conflict in Afghanistan has been to primarily develop the health care systems of the Afghan National Army (ANA) and Afghan National Police (ANP), and to contribute medical personnel to the civil-military Provincial Reconstruction Teams (PRTs) to build similar capacity at the community level.[55] PRTs are interim structures "designed to help improve stability in Afghanistan and Iraq by increasing the host nations' capacity to govern, enhance economic viability, and strengthen the local government's ability to deliver public services such as security and health care."[56]

In Iraq the PRTs are a joint DOS and DOD mission, operating under the command of both the Ambassador and the Commanding General of the Multinational Forces - Iraq. They are funded by two programs: the Quick Response Fund, used by the DOS and USAID, and the DOS's Provincial Reconstruction Development Council fund, which pays for small scale infrastructure projects at the provincial level.[57] In Afghanistan, the PRTs are under the operational command of the International Security

of Afghanistan Force.[58] Although personnel from the DOS, USAID, and US Department of Agriculture are members of the PRTs, these positions are almost exclusively funded by DOD.[59] The PRTs work hand-in-hand with civilian humanitarian organizations.

NGOs, IOs, and PVOs are at the forefront in responding to humanitarian crisis across the globe. In 2001, Secretary of State Colin Powell called NGOs "our force multipliers and an important part of our combat team."[60] In the health sector, post-conflict assistance focuses on three interventions that are usually sequential: meeting the immediate health needs of the affected population, restoring essential health services, and reconstructing or rehabilitating the health system. [61] Building, rebuilding, or rehabilitating a nation's health care delivery system to one that is effective and sustainable includes more than just building and staffing hospitals and clinics. "It includes health data collection and analysis, sector and program priority-setting, health financing, capital investment for infrastructure, policy making and regulation, workforce planning, training and education, and long-term operational capacity."[62] These are long-term projects that historically the DOD has not taken the lead on. The US military and DOS must interact with the humanitarian organizations collaboratively to enable the best outcome for the affected population, because these organizations will improve the public health sector by strengthening the local and national health systems and other public health capacity-building activities.[63] They also free the US military from using more of their resources to provide health care to affected populations.

Current US doctrine states that "the relationship between NGOs, IGOs and US military elements may be viewed as an associate or partnership relationship." These civilian organizations do not operate in military or governmental hierarchies and

therefore cannot have formal supporting or supported relationships with US military forces."[64] Unity of effort is the rule, not unity of command when coordinating with civilian organizations.

NGOs frequently are reluctant to work directly with the military, fearing they might appear to potentially compromise their impartiality and neutrality. In Afghanistan for example, NGO decisions regarding the recipients, type, and quantity, of aid are based solely on the organization's independent assessment of needs without discrimination and without promoting a particular political agenda or outcome.[65] If there is not close coordination with civilian organizations operating in the locality, short-term efforts by the US military may compete with or interfere with long-term goals of the civilian organizations as well as threaten their impartiality.[66]

The organizational structure of the coordinating body differs depending on the situation. During disaster responses and humanitarian assistance operations a governmental agency other than the Department of Defense (DOD) serves as the lead agency, with the DOD serving as a supporting agency.[67] During stability operations, the military enables complimentary efforts of local and international aid organizations to stabilize the public health situation within the commander's operational area, including strengthening the local and national health systems and other public health capacity-building activities.[68] Achieving measurable progress requires coordination and constant dialogue among all parties involved, eventually transitioning from military-led efforts to civilian organizations or the host nation.[69]

The chief medical officer of the task force will, through the task force commander, influence the command and control of the military medical assets, but that commander

does not command nor control the NGOs. During foreign humanitarian assistance operations, the combatant commander can establish a Humanitarian Assistance Coordination Center (HACC) or Civil Military Operations Center (CMOC) to assist with interagency coordination and planning. These coordination centers provide the critical link between the combatant commander and other USG agencies, IGOs, and NGOs that are participating in a foreign humanitarian assistance (FHA) operation.[70] This can be quite challenging. "Different agencies are not structured to work in a coordinated fashion; each agency has its own set of objectives, priorities, and ways of doing business."[71]

Funding sources is another complicated issue. The DOD has developed the Commander's Emergency Response Program funds which can be used for humanitarian relief and reconstruction, and the DOS has Overseas Humanitarian Disaster and Civic Assistance funds.[72] USAID, the Afghanistan Ministry of Public Health, and each of the IOs, NGOs, and PVOs also have their own funding; each source of funding comes with their own specific administrative rules and regulations.[73] This resulted in decentralized and uncoordinated processes for planning and execution among the many agencies and units in Afghanistan; this approach is unsustainable over the long-term.[74]

The medical efforts of the joint and combined military forces must be synchronized and aligned with those of the civilian aid organizations to create sustainable effects and processes. One proposal by the Combined Joint Task Force - 101 is to have the health care system development under the control of an appropriately resourced, single, joint medical command and control element (JMC2E).[75] Just as the

CJTF-Surgeon is responsible for and appropriately staffed to coordinate the health service support in theater, a health sector development cell, under the CJTF/JMC2E-Surgeon would be staffed with people who have the requisite skills and experience. Personnel selected to staff this cell should have an appropriate mixture of health care administration and clinical expertise including public health.[76] Liaison officers from the multiple civilian agencies are critical to ensuring the best coordination possible among the multiple agencies. Therefore, selecting experts with the right personalities to build, nurture, and sustain relationships and ensuring a unity of effort is critical. This proposed structure does risk worsening the perception of partiality of NGOs and other civilian relief organizations.

Improving the Relationship Between the Civilian Organizations and the Military

It is not in the DOD's interest to cause civilian humanitarian organizations to be more reluctant to work with military organizations because of concern about their organizations' perceived neutrality. In Afghanistan, the PRTs are under ISAF's operational command, and US-led PRTs report through the US military chain of command.[77] "Ten of the twelve US-led PRTs are US-led PRTs are managed by an interagency team composed of a military commander, and a representative from the DOS, USAID, and US Department of Agriculture."[78] Most of the staff of US-led PRTs are military personnel; from 2007-2008, the number of military personnel on US-led PRTs increased from 994-1021 while the total number of US Civilians, serving on both US and non-US PRTs rose only from 45-49.[79]

PRTs are a military-heavy organization. Created to execute joint military-civilian reconstruction operations, PRTs decrease the security for the civilian humanitarians by blurring the distinction between military and humanitarian operations."[80] The list of

duties that US PRTs perform include security, intelligence, and reconstruction activities, and there is no clear distinction between reconstruction, development, and assistance activities.[81] "Humanitarian literature does distinguish between military performance of direct assistance (e.g. running a health clinic), indirect assistance (transport and logistical support), and infrastructure (building roads, power generation, etc.).[82] In the first five months of 2004, data from US Central Command shows PRTs executing relief and reconstruction operations ahead of security; in contrast the PRTs best achievements occur when they constrain themselves to a primarily military or infrastructure development role.[83] Unfortunately, US-led PRTs have focused more on the quick impact projects, such as building clinics and digging wells for safe drinking water, and less on security or infrastructure development.[84]

Cost is an important concern. The Agency Coordinating Body for Afghan Relief, created in August 1988 in response to the demand from the many aid agencies and their international donors for a coordinated approach to humanitarian assistance in Afghanistan,[85] noted in 2002 that "the average cost of keeping a US Soldier on the ground in Afghanistan is $215,000.00 per year."[86] The 8 February 2001 version of Joint Publication 3-57, Civil Military Operations states that "military costs average ten times the cost of civilian agencies to perform the same relief operations."[87] Regarding health service support (HSS) the 2008 update of Joint Publication 3-57 states that "the use of HSS is generally a noncontroversial and cost-effective means of using the military element to support US national interests in another country. The focus of HSS initiatives, although possibly targeted toward the health problems in the operational

area, is not normally curative, but primarily long-term preventive and developmental programs that are sustainable by the host nation."[88]

Rebuilding the Afghan Health Care System

In 2009, the main challenges to rebuilding the health care system in Afghanistan included lack of security, poor infrastructure, economic hardship among the population, and poor coordination among government and health care providers.[89] The security situation in Afghanistan is unsafe and unpredictable[90]. The Afghanistan Ministry of Public Health (MoPH) currently contracts with NGOs for most of the health care in Afghanistan,[91] instead of focusing on comprehensive reconstruction of the civilian and military health systems.[92] There is improved communication between the MoPH and the NGO leadership, however at the district and provincial level, the interaction is inefficient, and at times efforts are duplicated.[93] There are separate health care facilities among the Afghan National Army (ANA), Afghan National Police (ANP), and the MoPH. The former senior medical officer for US Central Command, Brigadier General (Dr.) Bryan Gamble, said he wanted to "ensure both the military and civilian health care systems are raised relatively the same level to ensure the country did not have big discrepancies in standards of care, quality of care, and have-and-have-nots."[94]

Hundreds of millions of dollars have been spent constructing, renovating, equipping, and supplying hospitals, clinics, and on medical education programs.[95] Yet visits to some of these facilities show they are not operating as advertised, furthering the perception that the national government is failing the population.[96] A recommended solution by the Center of Technology and National Security Policy at National Defense University is the creation of a health sector reconstruction office in the Afghan national government, with the DOD serving as a significant partner along with personnel from

USAID, experts from the Department of Health and Human Services, the USDA, IOs, PVOs, NGOs, the International Security Assistance Force (ISAF), and academia.[97] The office would develop health care delivery projects, set priorities, and integrate and unify nationwide planning and integration with the government of Afghanistan, representatives of other nations, and the multiple humanitarian organizations.[98] Similar to the proposed CJTF/JMC2E-Surgeon cell, this office would have the coordinating authority with all health service activities in country, including the DOD projects with the ANA and ANP, and with ISAF.[99]

As the security situation in Afghanistan is still being stabilized, the DOD should be the organization initially responsible for leading this effort, and should be resourced appropriately along with the required authorities.[100] This will ensure that as the Taliban and insurgents are defeated across the nation, efficient development of local reconstruction projects can begin that will be synchronized with a national strategy of developing a nationwide health care system. In two of the geographic combatant commands, US Southern Command (USSOUTHCOM) and US Africa Command (USAFRICOM), the staffs have been restructured to embed expertise from multiple civilian departments to enhance coordination among interagency partners. [101] This has greatly improved the integration of civilian expertise, into the process of planning operations and increases the coordination and synchronization of efforts within the multiple US government agencies.[102] Civilian humanitarian organizations may be more amenable to working with such an health sector coordination office if the leader is a civilian DOD member as opposed to a uniformed leader.

Training

Correct training is the key to success of any operation. US military medical personnel are recognized experts worldwide in clinical, logistic, and administrative medical operations. No one provides better care, but we can always be better. Military medical personnel should also receive training on the key international guidelines that most of the NGOs, PVOs, and IOs follow. These include the Sphere Project Handbook, the USAID Field Operations Guide (FOG) for Disaster Assessment and Response, and the World Health Organization Millennium Developmental Goals.

Started in 1997 by a number of humanitarian NGOs and the Red Cross and Red Crescent, the Sphere Project developed a set of minimum standards in core areas of humanitarian assistance, in order to improve the quality of assistance provided to people affected by disasters, and to enhance the accountability of the humanitarian system in disaster response. It established a Humanitarian Charter and identified Minimum Standards to be attained in disaster assistance, in each of five key sectors: water supply and sanitation, nutrition, food aid, shelter and health services. This process led to the publication of the first Sphere handbook in 2000.[103]

The USAID FOG for Disaster Assessment and Response was developed by the U.S. Agency for International Development/Bureau for Democracy, Conflict, and Humanitarian Assistance/Office of U.S. Foreign Disaster Assistance (OFDA) as a reference tool for persons sent to disaster sites to undertake initial assessments or to participate as members of an OFDA Disaster Assistance Response Team (DART).[104] "The document contains information on general responsibilities for disaster responders, reference material for assessing and reporting on populations at risk, DART position descriptions and duty checklists, descriptions of OFDA stockpile commodities, general

information related to disaster activities, information on working with the military in the field, and a glossary of acronyms and terms used by OFDA and other organizations with which OFDA works."[105]

The United Nations (UN) Millennium Development Goals (MDG) are eight goals, three of which are health related, that all 191 UN member nations agreed to try to achieve by 2015.[106] Signed in September 2000, the declaration commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women.[107] "The eight MDGs are: (1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality, (5) improve maternal health, (6) combat HIV/AIDS, malaria, and other diseases, (7) ensure environmental sustainability, and (8) develop a global partnership for development."[108] US military medical personnel should be experts in these three international framing documents and declarations in order to ensure the best interaction and synchronization with the NGO, PVO, and IO partners and host nation medical leaders. This will enable DOD medical advisors to better attain unity of effort among all stakeholders as the help guide strategic planning for host nation health care systems.

Conclusion

"The condition of infrastructure is often a barometer of whether a society will slip further into violence or make a peaceful transition out of the conflict cycle."[109] The development, reconstruction, or rehabilitation of the health care delivery system of post-conflict nations is an important part of stability, security, transition, and reconstruction operations. Health care clinical and administrative personnel have the expertise in operating one of the largest health care systems in the world, the US military health

care system. While it is the responsibility of other organizations within the US government to assist other nations in developing and improving their health care delivery systems, because they have not only the technical expertise but the requisite cultural knowledge and sensitivities, these organizations are not staffed, resourced, and funded to fully execute this task. The DOD has the deployable personnel, resources, and technical expertise, both civilian and military, to better advise post-conflict governments on improving their health care systems. This will involve better partnerships with civilian humanitarian organizations to achieve an economy of scale in these efforts. Finally, strategic communications to the local population, allied and enemy populations, and the leaders of the host nation and the humanitarian organizations will be key to pushing messages that the DOD's efforts are to impartially assist in the host nation government in the successful reconstruction of a sustainable, efficient health care delivery system that will benefit the entire population of the post-conflict nation.

Endnotes

[1] Joint Publication 4-02, Health Services Support 31 October 2006 p IV-2.

[2] Jeff Drifmeyer, Craig Llewellyn. Toward More Effective Humanitarian Assistance. *Military Medicine,* Vol. 169, March 2004 p 164.

[3] Bradley Boetig. The 800-Pound Gorilla: The Interrelationship of Culture, Economics, and Security in Afghanistan, Small Wars Journal @ http://smallwarsjournal.com/blog/journal/docs-temp/280-boetig.pdf, Small Wars Foundation, 2009 accessed 2 February 2010.

[4] U.S. Department of State Office of the Coordinator for Reconstruction and Stabilization website @ http://www.state.gov/s/crs/ accessed 28 January 2010.

[5] Office of the Coordinator for Reconstruction and Stabilization website @ http://www.crs.state.gov/index.cfm?fuseaction=public.display&shortcut=4QJW accessed 28 January 2010.

[6] Todd Harrison, Analysis of the FY 2010 Defense Budget Request, Center for Strategic and Budgetary Assessments @ http://www.csbaonline.org/4Publications/PubLibrary/R.20090812.Analysis_of_the_FY/R.20090812.Analysis_of_the_FY.pdf accessed 15 February 2010 p. 11.

[7] Eugene V. Bonventre, Kathleen H. Hicks, and Stacy M. Okutani. US National Security and Global Health. An Analysis of Global Health Engagement by the US Department of Defense. A Report of the CSIS Global Health Policy Center - Working Draft April 2009, p. 9.

[8] "What is the Military Health System?" @ http://www.health.mil/About_MHS/index.aspx accessed 1 April 2010.

[9] Health System Reconstruction and Nation Building, RAND Center for Domestic and International Health Security @ http://www.rand.org/pubs/research_briefs/2007/RAND_RB9237.pdf accessed 21 January 2010 p. 2.

[10] Mark Selden. Notes From Ground Zero: Power, Equity and Postwar Reconstruction in Two Eras in *Policy Forum Online,* 04-25: June 30, 2004 accessed 21 January 2010.

[11] Ibid.

[12] Health System Reconstruction and Nation Building, RAND. p. 3

[13] Dragudi Buwa, Hannu Vuori. Rebuilding a Health Care System: War, Reconstruction, and Health Care Reforms in Kosovo, *European Journal of Public Health*, Vol 12, no. 2, p. 226.

[14] J Campbell, V. Percival, A Zwi. Ministerial Challenges: Post-Conflict, Post-Election Issues in Kosovo's Health Sector. *European Journal of Public Health*, 2003;13:177-81 as cited in Dragudi Buwa, Hannu Vuori. Rebuilding a Health Care System: War, Reconstruction, and Health Care Reforms in Kosovo, *European Journal of Public Health*, Vol 12, no. 2, p. 227.

[15] D. Buwa, H. Vuori. p. 226.

[16] Ibid.

[17] Ibid. p. 227.

[18] Ibid.

[19] Ibid.

[20] Ibid. p 228-9.

[21] Ibid. p. 228.

[22] Ibid.

[23] Health System Reconstruction and Nation Building, RAND p. 3.

[24] S Al Hasnawi. Iraqi Health Minister Works to Reform, Restore Neglected system. Interview by Rebecca Voelker. *Journal of the American Medical Association*, 2008: 300(6): 639,

as cited in Bruno Himmler. Guest Editorial, Health Care Diplomacy: The Iraq Experience and How It Can Shape the Future, *Military Medicine* December 2009 XVIII-XX.

[25] Ibid.

[26] Health System Reconstruction and Nation Building, RAND. p. 3.

[27] Ibid.

[28] Bruno Himmler. Guest Editorial, Health Care Diplomacy: The Iraq Experience and How It Can Shape the Future, *Military Medicine* December 2009 pp. xviii-xx.

[29] Health System Reconstruction and Nation Building, RAND. p. 4.

[30] Ibid.

[31] UNICEF. *Best estimates of social indicators for children in Afghanistan*. New York: UNICEF; 2005 as cited in Maureen Mayhew, Shame and simplicity in Afghanistan, Canadian Medical Association Journal, April 14, 2009.

[32] Health System Reconstruction and Nation Building, RAND. p. 4.

[33] Ibid. pp. 4-5.

[34] Health System Reconstruction and Nation Building, RAND Center for Domestic and International Health Security @ http://www.rand.org/pubs/research_briefs/2007/RAND_RB9237.pdf accessed 21 January 2010 p. 5.

[35] Department of Defense Directive 3000.05, Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations, November 28, 2005 as cited in Eugene V. Bonventre, Kathleen H. Hicks, and Stacy M. Okutani. US National Security and Global Health. An Analysis of Global Health Engagement by the US Department of Defense. A Report of the CSIS Global Health Policy Center - Working Draft April 2009, p. 5.

[36] Department of Defense Instruction: Stability Operations dated September 16, 2009 @ http://www.dtic.mil/whs/directives/corres/pdf/300005p.pdf accessed 15 January 2010.

[37] Quadrennial Defense Review Report, February 2010, Department of Defense, Washington DC p. iii.

[38] Building Health Security in Contemporary Afghanistan @ http://fhpr.osd.mil/intlhealth/healthSecurity.jsp accessed 10 February 2010.

[39] Arthur M. Smith, Craig Llewellyn. Humanitarian Assistance in US Foreign Policy: Is There a Constructive Role for Military Medical Services, *The DISAM Journal*, summer 1992. p 70-1.

[40] Ibid. p. 71.

[41] Ibid.

[42] Elspeth Cameron Ritchie, Robert L. Mott. Military Humanitarian Assistance: The Pitfalls And Promise Of Good Intentions in *Military Medical Ethics, Volume 2* in *Textbook of Military Medicine,* specialty editors, Thomas E. Beam, Linette R. Sparacino, Washington, DC: Office of The Surgeon General, US Department of the Army and Borden Institute, 2003 p. 808.

[43] Charles Mitchell, *The medic as an instrument of national policy, or what in the world is the department of defense doing in medical humanitarian assistance?* Carlisle Barracks, PA: US Army War College Study Project, 1991, p. 51 as cited in Arthur M. Smith, Craig Llewellyn. p. 71.

[44] Elspeth Cameron Ritchie, Robert L. Mott. p. 808.

[45] Joint Publication 1-02, Department of Defense Dictionary of Military and Associated Terms 12 April 2001 (as Amended Through 31October 2009)

[46] Jeff Drifmeyer, Craig Llewellyn, Toward More Effective Humanitarian Assistance, *Military Medicine*, Vol. 169, March 2004, p. 161.

[47] Jeff Drifmeyer, Craig Llewellyn: CDHAM Report 02-01. Overview of OHDACA Programs. Rockville, MD. Henry M. Jackson Foundation for the Advancement of Military Medicine, 2002 as cited in Drifmeyer, JE, Llewellyn, CH. Toward More Effective Humanitarian Assistance, *Military Medicine,* Vo.169, March 2004 p. 161.

[48] Tracy L. Nagus, Carrie J. Brown, Paula Konoske. Determining Medical Staffing Requirements for Humanitarian Assistance Missions. *Military Medicine*, Vol. 175, January 2010, p. 1.

[49] Arthur M. Smith, Craig Llewellyn, p 73.

[50] Eugene V. Bonventre. p 18.

[51] Ibid.

[52] HLSP Institute, Health System Reconstruction: Can It Contribute to State Building? Study commissioned by the Health and Fragile States Network, October 2008 as cited in Eugene V. Bonventre, Kathleen H. Hicks, and Stacy M. Okutani. US National Security and Global Health. An Analysis of Global Health Engagement by the US Department of Defense. A Report of the CSIS Global Health Policy Center - Working Draft April 2009, p. 5.

[53] Arthur M. Smith, Craig Llewellyn, p. 70.

[54] Ibid, p. 71.

[55] Building Health Security in Contemporary Afghanistan at http://fhpr.ost.mil/ intlhealth/healthSecurity.jsp accessed 10 February 2010.

[56] GAO, Provincial Reconstruction Teams in Afghanistan and Iraq, GAO-09-86R, United States Government Accountability Office, Washington DC, October 1, 2008, p 1.

[57] Ibid. p 3.

[58] Ibid. p. 2

[59] Ibid.

[60] Colin Powell, Remarks by Secretary of State Colin L. Powell to the National Foreign Policy Conference for Leaders of Non-Governmental Organizations, 26 October 2001, quoted in David Reiff, A Bed for The Night, Humanitarianism in Crisis, (New York: Simon Schuster, 2002) p. 236 as cited in Roger Nash. Demarcation between military and humanitarian activities in Afghanistan and the role of law, Essex Human Rights Review, Vol. 4 No. 2, September 2007 p. 5.

[61] Derick W. Brinkerhoff, From humanitarian and post-conflict assistance to health system strengthening in fragile states: clarifying the transition and the role of NGOs, November 1, 2008 @ http://www.healthsystems2020.org/content/resource/detail/2153/ accessed 2 February 2010, p.2.

[62] Ibid. p 2-3.

[63] Field Manual No. 3-07, Stability Operations, Headquarters, Department of the Army Washington, DC, 6 October 2008 p. 3-12.

[64] Joint Publication 1.0 Doctrine for the Armed Forces of the United States,02 May 2007 Incorporating Change 1, 20 March 2009 p VII-5.

[65] Agency Coordinating Body for Afghan Relief (ACBAR) Policy Brief: NGOs concerns and recommendations on civil military relations, Working Document: Version 1: 7 December 2002 at http://www.care.org/newsroom/specialreports/afghanistan/12092002_ACBAR.pdf accessed 18 October 2009.

[66] Eugene Bonventre. p. 5.

[67] Ibid.

[68] Field Manual No. 3-07, Stability Operations, Headquarters, Department of the Army Washington, DC, 6 October 2008 p. 3-12.

[69] Ibid.

[70] Joint Publication 3-08. Interagency, Intergovernmental, and Nongovernmental Organization Coordination During Joint Operations Volume 1, 17 March 2006, p. III-11.

[71] Building Health Security in Contemporary Afghanistan @ http://fhpr.osd.mil/ intlhealth/healthSecurity.jsp accessed 10 February 2010.

[72] Paul Brezinski, Monserrat Edie-Korleski, Timur S. Durrani, Doughlas Howard, and Michael Manansala. Health sector development in Afghanistan: the way forward, The Army Medical Department Journal, April-June 2009 p.53 @https://secure-akm.amedd.army.mil/ dasqaDocuments.aspx?type=1 accessed 2 February 2010.

[73] CJTF-101 Chief of Staff Memorandum: Fiscal year 2008 Resource Management Policy and Procedures, July 1, 2008 as cited in Paul Brezinski, et. al. p.53

[74] Paul Brezinski, et. al. p.53.

[75] Ibid.

[76] Ibid. p. 55.

[77] GAO, Provincial Reconstruction Teams in Afghanistan and Iraq, GAO-09-86R, p. 5.

[78] Ibid, p. 7.

[79] Ibid, p.8.

[80] Roger Nash. Demarcation between military and humanitarian activities in Afghanistan and the role of law, Essex Human Rights Review, Vol. 4 No. 2, September 2007 p.6.

[81] Ibid.

[82] Guidelines on the Use of Military and Civil Defense Assets to Support United Nations Humanitarian Activities in Complex Emergencies, March 2003 http://ochaonline.un.org/DocView.asp?DocID=426 as cited in Nash, p. 6.

[83] Nash, p. 6.

[84] Ibid. p. 7.

[85] ACBAR's Mission @ www.acbar.org accessed 12 February 2010.

[86] Estimate from Washington-based think tank, The Stimson Center (see www.stimson.org) as cited in ABCAR Policy Brief: NGO concerns and recommendations on civil-military relations. Working Document: Version 1; December 7, 2002 @ http://www.care.org/newsroom/ specialreports/afghanistan/12092002_ACBAR.pdf accessed 20 October 2009.

[87] Joint Publication 3-57 Civil Military Operations, 8 February 2001 @http://www.dtic.mil/doctrine/jel/new_pubs/jp3_57.pdf p. IV-6 as cited in Nash, p. 15

[88] Joint Publication 3-57 Civil-Military Operations, 8 July 2008, p. II-6 @ http://www.dtic.mil/doctrine/new_pubs/jp3_57.pdf accessed 3 February 2010.

[89] John R. Acerra, Kara Iskyan, Zubair A Qureshi, and Rahul K. Sharma. Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services, International Journal of Emergency Medicine, (2009), Vol. 2 p. 79.

[90] Ibid.

[91] Ibid, p. 80.

[92] Donald F. Thompson. The role of medical diplomacy in stabilizing Afghanistan. *Defense Horizons,* Center for Technology and National Security Policy, National Defense University, May 2008, No. 63, p.3.

[93] John R. Acerra, et al, p. 80.

[94] Building Health Security in Contemporary Afghanistan @ http://fhpr.osd.mil/intlhealth/healthSecurity.jsp accessed 10 February 2010.

[95] Donald F. Thompson, p.4.

[96] Ibid, p. 5.

[97] Ibid, p.6.

[98] Ibid.

[99] Ibid.

[100] Ibid, p. 7.

[101] Report to Congress on the Integration of Interagency Capabilities into Department of Defense Planning for Stability Operations, May 2009, Department of Defense, Washington, DC, p. 3.

[102] Ibid.

[103] "What is Sphere?", The Sphere Project, @ http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,17/Itemid,203/lang,english/ accessed 1 April 2010.

[104] Field Operations Guide for Disaster Assessment and Response, US Agency for International Development, Bureau for Democracy, Conflict, and Humanitarian Assistance Office of U.S. Foreign Disaster Assistance, Version 4.0, September 2005. p. xvii.

[105] Ibid.

[106] "Millennium Development Goals", World Health Organization, @ http://www.who.int/topics/millennium_development_goals/about/en/index.html accessed 1 April 2010.

[107] Ibid.

[108] Ibid.

[109] Donald F. Thompson, p. 7.